STATE OF ARIZONA
CHILDRENôS REHABILITATIVE SERVICES (CRS)

Medicaid Managed Care Program

FINANCIAL REPORTING GUIDE

FOR

CRS Contractors

State of Arizona
Arizona Department of Health Services
Office of Children with Special Health Care Needs (OCSHCN)

Issue Date: January 2004

1.00 Purpose and Objective of the Guide

The purpose of the Financial Reporting Guide For CRS Contractors (Guide) is to set forth the quarterly and annual financial reporting requirements for CRS Contractors under contract with the Arizona Department of Health Services / CRS Administration (CRSA).

The primary objective of the Guide is to establish consistency and uniformity in financial reporting among CRS Contractors. This Guide is neither intended to limit the scope of audit procedures to be performed during the Contractorôs annual certified audit, nor to replace the independent certified public accountant's judgment as to the work to be performed. It is instead intended to define certain additional procedures and analysis to be performed and reported on by the independent certified public accountant on an annual basis and by the applicable CRS Contractor management on a quarterly basis.

1.01 Background

In July 2000, the Arizona Department of Health Services implemented a diagnosis based capitation rate system which provides coverage for CRS medical services for Title XIX and Title XXI eligible children under the age of 21 years old that have been determined to have a CRS eligible condition and are enrolled with a CRS Contractor. The goal of the managed care clinic-based delivery system is to administer innovative managed care programs effectively and efficiently, and continually improve accessibility and delivery of quality health care to eligible members through integrated health care systems.

1.02 Effective Dates and Reporting Time Frames

The provisions and requirements of this Guide are effective for calendar quarters beginning on and after January 1, 2004. As deemed necessary, amendments and/or updates to this Guide may be issued by the CRS Administration. CRS Contractors will be given the opportunity to submit their comments before changes are implemented.

Quarterly reporting is due within **45** days of each quarter end. A draft of the annual audited financial statements and management letter is not required, but is encouraged to be submitted within **90** days of the CRS Contractor's calendar year end. Final annual financial reports are due within **100** days of the CRS Contractor's calendar year end.

For selected reports, the CRS Contractor is required to follow a predetermined format for reporting enrollment and financial data.

The following table depicts the overall reporting requirements and scheduling.

Report #	Report Name	Frequency	Due Date [1]	Format
1	Enrollment	Quarterly	30 Days After Quarter End	Predetermined
2	Balance Sheet	Quarterly	30 Days After Quarter End	Predetermined
3	Analysis of Revenue and Expenses	Quarterly	30 Days After Quarter End	Predetermined

4	Claims Payable (RBUCs and IBNRs)	Quarterly & Annual	30 Days After Quarter End	Predetermined
5	Claims Lag Report	Quarterly	30 Days After Quarter End	Predetermined
N/A	Footnotes	Quarterly	30 Days After Quarter End	Predetermined Minimums
N/A	Certification Statement	Quarterly	30 Days After Quarter End	Predetermined
N/A	Draft Annual Audit Report	Annual	80 Days After Year End	N/A
N/A	Draft Management Letter (Encouraged but not required)	Annual	80 Days After Year End	N/A
N/A	Final Annual Audit Report	Annual	100 Days After Year End	N/A
N/A	Final Management Letter	Annual	100 Days After Year End	N/A
N/A	Annual Reconciliation Report	Annual	100 Days After Year End	Suggested

[1] If a due date falls on a weekend or State recognized holiday, reports will be due the next business day.

2.00 General Instructions and Submission

The following are general instructions for completing the various quarterly reports required to be submitted by the CRS Contractor to the CRSA. The primary objective of these instructions is to promote uniformity in reporting and to ensure that the financial statements and reports are prepared in accordance with generally accepted accounting principles.

Generally accepted accounting principles (GAAP) are to be observed in the preparation of these reports.

All quarterly or annual reports must be completed and submitted to the CRSA within the due date. The CRSA may extend a report deadline if a request for an extension is communicated, in writing, and is received at least ten business days prior to the report deadlines. Request for extension must include the reason for the requested extension and the date by which the report will be filed.

The CRS Contractor must submit the forms on diskette or via e-mail. **A signed and dated Certification Statement is required for all quarterly report submissions.**

Each report submission (either on diskette or e-mail) should be accompanied by a printed copy for reference and verification. All reports should be addressed to the following person and address:

Jennifer Vehonsky, Division Chief of Compliance
CRS Administration

150 North 18th Avenue, Suite 330
Phoenix, AZ 85007-3243

Phone: (602) 542-2879
Fax: (602) 542-2589
Email: clayne@hs.state.az.us

Normally, line titles and columnar headings of the various reports are self-explanatory and therefore constitute instructions. However, specific instructions are provided for items that may have some question as to content. Any entry for which no specific instructions are included should be made in accordance with sound accounting principles and in a manner consistent with related items covered by specific instructions.

Always utilize predefined categories or classifications before reporting an amount as "OTHER". For any material amounts included in the "OTHER" category, **provide details and explanations**. For this purpose, **material** is defined as comprising an amount ≥ 5% of the total for each section. For example, if Other Income is reported that is less than 5% of Total Revenues, no disclosure is necessary. However, if Other Medical Expense is reported which equals 8% of Total Medical expenses, disclosure would be necessary. Disclosure, with detail explanation, should be prepared in a separate sheet accompanied with the report.

Unanswered questions and blank lines or schedules will not be considered properly completed. If no answers or entries are to be made, write "None", not applicable (N/A), or "-0-" in the space provided.

All amounts are to be reported in whole dollars only. The CRS Contractor may elect to report the amounts to the nearest whole dollar or through truncation of digits less than a dollar. (Examples: $504,932.65 may be reported as $504,933 by rounding or as $504,932 by truncation).

3.00 General Information – Quarterly Reporting

The following financial statements are to be reported on a quarterly basis. See Section 1.02 for the due dates of these reporting requirements.

- Certification Statement
- Enrollment (Report #1)
- Balance Sheet (Report #2)
- Analysis of Revenues and Expenses (Report #3)
- Claims Payable (RBUCs and IBNRs) (Report#4)
- Claims Lag Report (Report #5)
- Footnotes

3.01 Report #1 – Enrollment Table

Member Month Equivalents ï These columns disclose member month equivalents per month by high, medium and low risk categories and for the state only category as shown on the report. A member month is equivalent to one member for whom capitation-based revenue has been recognized for the entire month. Where revenue is recognized for only part of a month for a given individual, a partial, pro-rated member month should be

counted. A partial member month is pro-rated based on the actual number of days in a particular month.

Year-to-Date (YTD) ï The year-to-date column should equal the sum of as many months as have been completed through the quarter being reported. For example, after the first quarter, the year-to-date column will equal the first three monthsô numbers, but after the second quarter, the year-to-date column will equal the sum of the first six months.

3.02 Report #2 – Balance Sheet

CURRENT ASSETS are assets that are expected to be converted into cash or used or consumed within one year from the date of the balance sheet. Restricted assets for the general performance bond, contracts, reserves, etc., are not to be included as current assets.

Minimum Specification	Inclusion	Exclusion
Cash and Cash Equivalents	Cash and cash equivalents, available for current use. Cash equivalents are investments maturing 90 days or less from the date of purchase.	Restricted cash (and equivalents) and any cash (and equivalents) pledged by the CRS Contractor to satisfy the CRSA performance bond requirement.
Short-term Investments	Investments that are readily marketable and that are expected to be redeemed or sold within one year of the balance sheet date. **Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.**	Investments maturing 90 days or less from the date of purchase and restricted securities. Also exclude investments pledged by the CRS Contractor to satisfy the CRSA performance bond requirement.
Accounts Receivable	Includes monies due the Contractor for services rendered for which payment has not yet been received	
Investment Income Receivable	Income earned but not yet received from cash equivalents, investments, performance bonds, and short and long-term investments.	
Other Current Assets	Include all other current assets not accounted for elsewhere on the balance sheet. Any receivables from providers should be accounted for here. They should not be netted against the IBNRs. **Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.**	

CURRENT LIABILITIES are obligations whose liquidation is reasonably expected to occur within one year from the date of the balance sheet.

Minimum Specification	Inclusion	Exclusion
Accounts Payable	Amounts due to creditors for the acquisition of goods and services (trade and administrative vendors) on a credit basis.	Amounts due to providers related to the delivery of health care services.
Accrued Administrative Expenses	Accrued expenses and management fees and any other amounts, estimated as of the balance sheet date (i.e., payroll, taxes). Also include accrued interest payable on debts.	
Medical Claims Payable (Detail in Report #4)	The total of reported but unpaid claims (RBUCs) and incurred but not reported claims (IBNRs).	
Management Fee Payable to Parent Company	Includes all management services and/or corporate cost allocation plans. **Note, the CRSA reserves the right to perform a thorough review of actual management fees charged and/or corporate allocations made. If the fees or allocations actually paid out are determined to be unjustified or excessive, appropriate actions will be taken. Also, material amounts (greater than 5% of total liabilities) should be disclosed and fully explained in a separate sheet.**	
Other Current Liabilities (Specify)	Those current liabilities not specifically identified elsewhere. **Note, material amounts (greater than 5% of total assets) should be disclosed and fully explained in a separate sheet.**	

EQUITY includes preferred stock, common stock, treasury stock, additional paid-in capital, contributed capital, and retained earnings/fund balance.

Minimum Specification	Inclusion	Exclusion
Preferred Stock	Should equal the par value, or in the case of no-par shares, the stated or liquidation value, per share multiplied by the number of issued shares.	
Common Stock	Should equal the par value, or in the case of no-par shares, the stated value, per share multiplied by the number of issued shares.	
Additional Paid-in Capital	Amounts paid and contributed in excess of the par or stated value of shares issued.	
Contributed Capital	Capital donated to the CRS Contractor. Describe the nature of the donation as well as any restrictions on this capital in the notes to financial statements.	
Retained Earnings	The undistributed and unappropriated amount of earned surplus.	

3.03 **Report #3 – Analysis of Revenues and Expenses**

Report revenues and expenses using the full accrual method according to GAAP.

MEMBER MONTH EQUIVALENTS Automatic transfer of information from Report #1 ï Enrollment Table.

REVENUES All revenues should be reported by rating category (Category of High, Medium, Low, State Only, and other).

Minimum Specification	Inclusion	Exclusion
Capitation Revenue	Revenue recognized on a prepaid basis for provision of covered services.	
Investment Income	All investment income earned during the period.	Do **not** net interest income and interest expense together.
Fixed fee ï State only	All State only income earned during the period	
Other Income (Specify)	Revenue from sources not identified in the other revenue categories. **Note, material amounts (greater than 5% of total revenues) should be disclosed and fully explained in a separate sheet.**	

MEDICAL EXPENSES All medical expenses must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA
Hospital Inpatient – In State	Inpatient hospital costs including ancillary services for enrollees while confined to an acute care hospital, including out of area (OOA) hospitalization.	Do not include inpatient costs provided in an out of state facility.
Hospital Outpatient ï In State	The facility component of the outpatient visit. The visit can be free standing or a hospital outpatient department.	Do not include outpatient costs provided in an out of state facility.
Hospital Inpatient / Out patient ï Out of State	Inpatient hospital costs including ancillary services for enrollees while confined to an acute care hospital. Also include the facility component of the outpatient visit. The visit can be free standing or a hospital outpatient department.	Do not include inpatient or outpatient costs that were provided in state.
Physician ï Regional Clinic	All costs associated with medical services provided by a physician or other practitioner in a regional clinic including only non-salaried physicians and other non-salaried practitioners that are compensated on a fee for service, hourly, session	Do not include any physician costs for salaried physicians or salaried other practitioners

Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA
	rate basis or comparable basis.	
Physician ï Outreach Clinic	All costs associated with medical services provided by a physician in an outreach clinic including only non-salaried physicians and other non-salaried practitioners that are compensated on a fee for service, hourly, session rate basis or comparable basis.	Do not include any physician costs for salaried physicians or salaried other practitioners
Physician ï Non Clinics	All costs associated with medical services provided by a physician or other practitioner in a setting other than a regional or outreach clinic.	Do not include physician costs provided in a regional or outreach clinic setting. or salaried physicians or other practitioners
Clinic ï Professional Staff (Salaried)	All costs (including payroll taxes) associated with medical services provided by physicians, other practitioners, and medical personnel in a regional clinic including only salaried personnel.	Exclude costs for physician, other practitioner, and other medical staff that are not considered part of the CRS Contractor staff.
Medical Support Administration - Clinics	All other costs related to the provision of medical services within a regional or outreach clinic. Costs should include allocation of rent, depreciation, telephone, and other utilities.	Non-Clinic Administration
Medical Supplies and Other Costs - Clinics	All costs associated with medical supplies provided for services rendered in either a regional clinic or outreach clinic setting.	
Pharmacy	Expenses for drugs provided that include both ingredient costs and dispensing fees. Also include any clinical staffing and related administrative pharmacy costs.	
Durable Medical Equipment	The cost of durable medical equipment (DME).	
All Other Medical	All other medical costs not related to any of the above categories of service.	
Non Covered	All costs for services not specifically	

Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA	Discuss pertinence of these positions for CRSA
Services	identified as a CRS covered Service	

REINSURANCE and THIRD PARTY LIABILITY All reinsurance and third party liability recoveries must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Reinsurance	All reinsurance expected to be recovered from the State or reinsurance company under a reinsurance agreement.	
Third Party Liability	Cost sharing revenue, including third party sources.	

ADMINISTRATION All administrative costs must be reported by rating category (Category of High, Medium, Low, State Only, and Other).

Minimum Specification	Inclusion	Exclusion
Administrative Compensation	All costs (including payroll taxes) associated with non-clinical administrative services provided by personnel in a regional or outreach clinic.	Administration - Exclude Administrative Fees owed to Parent Company
Interest expenses	Interest expenses	Do **not** net interest income and interest expense together.
Occupancy, Depreciation & Amortization	Occupancy, Depreciation & Amortization costs related to services provided in a regional or outreach clinic	
Administrative Allocations from Affiliate/Parent	Administrative costs allocated to the CRS Contractor for the current period by a parent or affiliate management company.	

3.04 Report #4 – Medical Claims Payable (RBUCs and IBNRs)

Reported but unpaid claims (RBUCs) are to be reported by the appropriate expense categories. A claim becomes an RBUC the day it is received by the CRS Contractor, not

the day it is processed/adjudicated. The incurred but not reported (IBNR) claims should be reported in the second to last column by the appropriate category.

3.05 Report #5 – Claims Lag Reports

Analyzing the accuracy of historical medical claims liability estimates is helpful in assessing the adequacy of current liabilities. The following information is provided as guidelines to help make this analysis (also see Appendix C).

Lag tables are used to track historical payment patterns. When a sufficient history exists and a regular claims submission pattern has been established, this methodology can be employed. All CRS Contractors should use lag information as a validation test for accruals calculated using other methods, if it is not the primary methodology employed. Typically, the information on the schedules is organized according to the month claims are incurred on one axis (horizontal) and the month claims are paid by the CRS Contractor on the other axis (vertical). Remember, it is best to track specific information by population risk group and by category of service, as each population may have different characteristics.

Once a number of months becomes "fully developed" (i.e. claims submissions are thought to be complete for the month of service), the information can be utilized to effectively estimate IBNRs. This is done by computing the average period over which claims are submitted historically and applying this information to months which are not yet fully developed.

Although not currently required, a separate table could be completed for the following categories of service:

1) Hospital
2) Physician
3) All Other

Claims Lag Table Example

The following simple example demonstrates the lag table approach discussed above.

Fully Developed Table

	Month Incurred (Date of Service)					
Month Paid	January	February	March	Total	Percent of Total	Cumulative Percent
Current	$ 1,400	$ 800	$ 2,000	$ 4,200	10.0%	10.0%
1st Prior	$ 8,200	$ 8,750	$ 8,500	$25,450	60.6%	70.6%
2nd Prior	$ 3,700	$ 2,800	$ 3,750	$10,250	24.4%	95.0%
3rd Prior	$ 700	$ 650	$ 750	$ 2,100	5.0%	100.0%
TOTAL	$14,000	$13,000	$15,000	$42,000	100.0%	

This table indicates that 10% of all claims are reported and paid in the month services are rendered; in the next month, 60.6% of the claims are paid; and so on. In this example, all claims are shown to be paid within four months from the date of service (i.e., fully developed). This may be unrealistic but it satisfies the needs of this example. The above

information can be used to calculate IBNRs by looking at claims payment experience for the three months prior to the balance sheet date.

By dividing claim payments to date by the decimal form of the cumulative percent developed from the fully developed table for the applicable month, an estimate is made of each month's total claims to be experienced for the period. Subtracting the total claims paid to date from this estimate yields the estimated claims expense accrual.

The following steps must be taken:

In order to estimate the total claims expense as of the end of June,

1. For each month not yet fully developed, the cumulative percentage (obtained from the fully developed table) should be divided into the total amount of claims paid to date for each month. The result will be the estimated total claims expense for each month.

2. Subtract all claims already paid or received (RBUC's) for that month from the estimated total claims expense for each month. The remainder represents your IBNR estimates.

	Month Incurred			
Month Paid	April	May	June	Total
Current	$ 1,600	$ 1,900	$1,600	$ 5,100
1st Subsequent	$ 9,700	$10,600	$ ------	$20,300
2nd Subsequent	$ 3,800	$ ------	$ ------	$ 3,800
3rd Subsequent	$------	$ ------	$ ------	$ ------
TOTAL	$15,100	$12,500	$1,600	$29,200
Divided by Cumulative Percent Paid	95.0%	70.6%	10.0%	N/A
Estimated Total Claims Expense	$15,895	$17,705	$16,000	$49,600
Less: Amount Paid to Date	(15,100)	(12,500)	(1,600)	(29,200)
Less: RBUCôs	(100)	(200)	(1,100)	(1,400)
Estimated Claims Accrual (IBNR)	$695	$5,005	$13,300	$19,000

It should be noted that the estimates developed by this lag technique should be monitored for reasonableness. This is especially true for the most recent months where the information is less developed than the older months. If the calculation is producing an unusually low or high total claims expense for any particular month it should be investigated for validity. An example of a possible solution is to override the skewed portion of the IBNR with an average monthly cost less the amount paid to date for that month.

3.06 Footnotes

The Contractor shall prepare footnote disclosures to accompany each set of quarterly financial reports. The footnotes should provide sufficient detail and complete disclosure of significant accounting assumptions, estimates, and changes in financial condition and significant ownership/control relationships.

In addition, the Contractor shall report the pricing methodology utilized to determine medical expenditures for the period. This shall be done at the same level of detail as is required for medical expenditures in Report #3 ï Analysis of Revenues and Expenses. If multiple pricing schemes are utilized by the Contractor for a particular category of service, disclose the most prevalent approaches utilized (based on total expenditures). For example, if the Contractor reimburses inpatient hospital service providers using a percentage of billed charges approach for affiliated entities and out-of-state hospitals, and the AHCCCS tiered per-diem schedule for unaffiliated hospitals in state, both should be disclosed, along with the percent of billed charges paid to affiliates and non affiliated providers. The table below should be utilized for these disclosures.

Sample Disclosure Table

Categories of Service	**Method of Reimbursement/Basis of Expense Recognition**	**Approximate Percentage of Expenditures**
Hospital Inpatient – In State	1) Affiliated Hospitals ï Percentage of billed charges (60%) 2) Non-Affiliated Hospitals ï AHCCCS Tiered Per Diem	1) 95% 2) 5%
Hospital Outpatient – In State	1) Affiliated Hospitals ï Percentage of billed charges (55%) 2) Non-Affiliated Hospitals ï AHCCCS cost-to-charge ratio	1) 90% 2) 10%
Hospital Inpatient / Out patient ï Out of State	1) Percentage of billed charges (varies by contract) 2) Negotiated rate per patient	1) 60% 2) 40%
Physician ï Regional Clinic	1) Physicians ï Percent of Billed Charges (80%) 2) Physicians ï Percent of AHCCCS FFS rates (95%) 3) Non-Physicians ï Hourly rate (per contract)	1) 40% 2) 30% 3) 30%
Physician ï Outreach Clinic	1) Physicians ï Percent of Billed Charges (850%) 2) Physicians ï Percent of AHCCCS FFS rates (100%) 3) Non-Physicians ï Hourly rate (per contract)	1) 60% 2) 10% 3) 30%
Physician ï Non Clinics	1) Physicians ï Percent of Billed Charges (70%) 2) Physicians ï Percent of AHCCCS	1) 20% 2) 65%

Categories of Service	Method of Reimbursement/Basis of Expense Recognition	Approximate Percentage of Expenditures
	FFS rates (105%) 3) Non-Physicians ï Hourly rate (per contract)	3) 15%
Clinic ï Professional Staff (Salaried)		
Medical Support Administration - Clinics		
Medical Supplies and Other Costs - Clinics	All costs associated with medical supplies provided for services rendered in either a regional clinic or outreach clinic setting.	
Pharmacy	Discount - AWP less 15% Dispensing Fee - $2.75 Administration Fee ï Not applicable	100% 100%
Durable Medical Equipment	AHCCCS FFS Fee Schedule	100%
All Other Medical		
Non Covered Services		

4.00 General Information – Annual Reporting

The CRS Contractor is required to submit certain financial reports and schedules to the CRSA on an annual basis. See Section 1.02 for the due dates of the annual reporting requirements.

The annual financial reports and schedules must disclose the CRS line of business (including assets, liabilities, equity, revenue, and expenses) independent of any other line of business in which the CRS Contractor may be engaged.

For example, if a CRS Contractor also has a contract to provide services not related to its CRS Contract with ADHS, the financial statements must at least separate these lines of business in the form of additional supplemental schedules, if they are not separately presented in the financial statements themselves. In addition, **all required supplemental schedules listed in Section 4 are to represent the CRS line of business exclusively.**

4.01 Required Statements and Supplemental Schedules

The following statements and schedules must be included in the audited financial statements accompanied by an independent certified public accountant's report thereon.

- Balance Sheet
- Statement of Revenues and Expenses and Changes in Equity/Net Assets
- Footnotes

Other required, supplemental schedules include:

- Claims Payable (See Report #4)
- Final Management Letter
- Annual Reconciliation Report

4.02 Annual Reconciliation Report

In addition to the annual audited financial statements, a reconciliation of the CRS Contractor's final year-to-date quarterly financial statements to the annual audited statements must be submitted with the final audited statements. (See Appendix B for example)

5.00 Glossary of Terms

CAPITATION. A fixed premium that is paid per eligible member periodically (usually monthly) to a contractor or subcontractor as compensation for providing health care services for the period.

CRS CONTRACTOR. Organization or entity agreeing through a direct contracting relationship with the ADHS/CRS Administration to provide those goods and services specified by contract.

DAY. Day means calendar day unless otherwise specified.

ENROLLMENT. Process by which a person who has been determined eligible becomes qualified to receive CRS covered services from a CRS Contractor.

FEE-FOR-SERVICE. Payment mechanism by which contractors, subcontractors and other providers of care are reimbursed upon submission of valid claims for specific covered services and equipment provided to eligible persons.

INCURRED BUT NOT REPORTED CLAIMS (IBNRs). The liability for services rendered for which claims have not been received.

INPATIENT. A patient who is provided with room, board, and general nursing service in a hospital setting and is expected to remain at least overnight and occupy a bed.

OUTPATIENT. A patient who is not confined overnight in a health care institution.

PHARMACY. Establishment where prescription orders are compounded and dispensed by, or under the direct supervision of, a licensed pharmacist.

PROVIDER. A person or entity that undertakes to provide health care services.

RELATED PARTY TRANSACTIONS. Transactions, whether or not in the ordinary course of business, with directors, management, medical staff, or other related parties.

REPORTED BUT UNPAID CLAIMS (RBUCs). A claim is considered received the day it is physically received at the CRS Contractor.

THIRD PARTY. An individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or member.

6.0 Appendices

(A) Quarterly Certification Statement
(B) Reconciliation - Annual Audit and CRS Contractor Year End Quarterly Financial Statements
(C) Medical Claims Payable (RBUCs and IBNRs) General Information

[END OF ATTACHMENT]

APPENDIX A: QUARTERLY CERTIFICATION STATEMENT

QUARTERLY CERTIFICATION STATEMENT OF

<CRS CONTRACTOR NAME>

TO THE

Arizona Department of Health Services

FOR THE QUARTER ENDED

_____, 200_____
(Month and Day) (Year)

Name of Preparer _____

Title _____

Phone Number (____) _____

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge and has been prepared in accordance with the reporting instructions provided by the State. Any variances from GAAP in preparing this information have been identified and disclosed in writing to the State. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in the termination of a Program Contractorôs agreement or contract with the Arizona Department of Health Services. **Failure to sign the Certification Statement will result in ADHS' non acceptance of the attached reports. Attached is the methodology used to create these financial statements.**

_____ _____
Date Signed Chief Executive Officer
(Name and Title typewritten)

_____
Signature

_____ _____
Date Signed Chief Financial Officer
(Name and Title typewritten)

_____
Signature

APPENDIX B: ANY CRS CONTRACTOR RECONCILIATION

Annual Audit and CRS Contractor Year End Quarterly Financial Statements

For the Period Ended June 30, 200X

	YTD Quarterly Reporting	Increase / (Decrease)	Final Audit
Balance Sheet:			
Receivable from the ADHS	$2,400,000	$100,000	$2,500,000 (a)
Medical Claims Payable	1,392,500	(142,500)	1,250,000 (b)
Change in Equity / Net Assets:	$3,792,500	$(42,500)	$3,750,000
Statement of Revenues & Expenses:			
Capitation Revenue	$1,100,000	$100,000	$1,200,000 (a)
Hospital Inpatient	9,090,000	(90,000)	9,000,000 (b)
Physician ï Regional Clinic	7,892,500	(45,000)	7,847,500 (b)
All Other Medical	4,507,500	(7,500)	4,500,000 (b)
Change in Net Income(Loss):	$22,590,000	$(42,500)	$22,547,500

(a) Additional capitation revenue was identified by a reconciliation notice from ADHS.

(b) Balances for medical claims payable and expense changed due to revisions of IBNR estimates based upon subsequent claims payments.

APPENDIX C: MEDICAL CLAIMS PAYABLE (RBUCS AND IBNRS) GENERAL INFORMATION

There are three primary components of claims expense:

Paid claims,
Received but unpaid claims (RBUCs). Note that a claim is considered an RBUC immediately upon receipt by the CRS Contractor and should be tracked as such. The processing status of an RBUC is either pended, in process, or payable, and
Incurred but not reported claims (IBNRs).

The first two components of claims expense are readily identifiable as part of the basic accounting systems utilized by the CRS Contractors. Since these components, along with a well-established prior authorization and referral system, form the basis for estimation of IBNRs, it is important that CRS Contractors have adequate claims accrual and payment systems. These systems must be capable of reporting claims on an incurred or date of service basis, have the capacity to highlight large outlier cases, possess sufficient internal controls to prevent and detect payment errors, and conform to regular payment patterns. Once IBNR estimates have been established, it is imperative that the CRS Contractors continually monitor them with reference to reported and paid claims.

Claims expense cannot be properly evaluated without adequate consideration of current trends and conditions. The following summarizes claims environment factors that should be considered:

Changes in policy, practice, or coverage
Fluctuations in enrollment by rate code category
Expected inflationary trends
Trends in claims lag time
Trends in the length of hospital inpatient stay by rate code category
Changes in rate code case mix
Changes in contractual agreements

IBNRs are difficult to estimate because the quantity of service and exact service cost are not always known until claims are actually received. Since medical claims are the major expenses incurred by the CRS Contractors, it is extremely important to accurately identify costs for outstanding unbilled services. To accomplish this, a reliable claims system and a logical IBNR methodology are required.

Selection of the most appropriate system for estimating IBNR claims expense requires judgment based on a CRS Contractorôs own circumstances, characteristics, and the availability and reliability of various data sources. Using a primary estimation methodology, along with supplementary analysis usually produces the most accurate IBNR estimates. Other common elements needed for a successful IBNR system are:

1. An IBNR system must function as part of the overall financial management and claims system. These systems combine to collect, analyze, and share claims data. They require effective referral, prior authorization, utilization review, and discharge planning functions. Also, the CRS Contractor must have a full accrual accounting system. Full accrual accounting systems help properly identify and record the expense, together with the related liability, for all unpaid and unbilled medical services provided to CRS Contractor members.

2. An effective IBNR system requires the development of reliable lag tables that identify the length of time between provision of service, receipt of claims, and processing and payment of claims by major provider type (hospital, medical compensation and other medical). Reliable claims/cash disbursement systems generally produce most of the necessary data. Lag tables, and the projections developed from them, are most useful when there is sufficient, accurate claims history which shows stable claims lag patterns. Otherwise, the tables will need modification, on a proforma basis, to reflect corrections for known errors or skewed payment patterns. The data included in the lag schedules should include all information received to date in order to take advantage of all known amounts (i.e., RBUCs and paid claims).

3. Accurate, complete, and timely claims data should be monitored, collected, compiled, and evaluated as early as possible. Whenever practical, claims data collection and analysis should begin before the service is provided (i.e., prior authorization records). This prospective claims data, together with claims data collected as the services are provided, should be used to identify claims liabilities.

4. Claims data should also be segregated to permit analysis by major risk group and category of service.

5. Subcontractor agreements should clearly state each party's responsibility for claims/encounter submission, prior notification, authorization, and reimbursement rates. These agreements should be in writing, clearly understood and followed consistently by each party.

6. The individual IBNR amounts, once established, should be monitored for adequacy and adjusted as needed. If IBNR estimates are subsequently found to be significantly inaccurate, analysis should be performed to determine the reasons for the inaccuracy. Such an analysis should be used to refine a CRS Contractor's IBNR methodology if applicable.

There are several different methods that can be used to determine the amount of IBNRs. The CRS Contractor should employ the one that best meets its needs and accurately estimates its IBNRs. **If a CRS Contractor is utilizing a method different from the methods included herein, a detailed description of the process must be submitted to the ADHS/CRS Administration for approval**. The IBNR methodology used by the CRS Contractor must be evaluated by the CRS Contractor's independent accountant or actuary for reasonableness.

Case Basis Method

Accruals are based on estimates of individual claims/episodes. This method is generally used for those types of claims where the amount of the cost will be large, requiring prior authorization. The final estimated cost can be made after the services have been authorized by the CRS Contractor. For example, if a CRS Contractor knows how many hospital days were authorized for a certain time period, and can incorporate the contracted reimbursement arrangement(s) with the hospital(s), a reasonable estimate should be attainable. This is also the most common and can be the most accurate method for small and medium sized organizations.

Average Cost Method

As the name suggests, average costs of services are used to estimate total expense. The expenses estimated using average costs are then reduced by claims that have been paid or claims that have been received but are unpaid (RBUCs). There are two primary average cost methods which are discussed below. It is important to note that each method may be used by a CRS Contractor to estimate different categories of IBNRs (i.e., hospitalization vs. all other medical). Also, either method may be utilized in conjunction with other IBNR methodologies discussed in this document.

Per Member Per Month (PMPM) Averages

Under this method the average costs are based on the population rate for each risk group over a given time period, in this case one month. The average cost may cover one or more service categories and is multiplied by the number of members in the specific population to estimate the total expense of the service category. Any claims paid and RBUCs for the service category are subtracted from the expense estimate which results in the IBNR liability estimate for that service category.

Per Diem or Per Service Averages

Averages for this method are of specific occurrences known by the CRS Contractor at the time of the estimation. Therefore, it is first necessary to know how many hospital days, procedures or visits were authorized as of the date for which the IBNR is being estimated. Again, once the total expense has been estimated, the amount of related paid claims and RBUCs should be subtracted to get the IBNR liability. This method is primarily used for hospitalization IBNRs as CRS Contractors know the amount of hospital days authorized at any given time.